MONTHLY BULLETIN
PENNSYLVANIA·DEPARTMENT·OF·WELFARE

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THE STATE'S WORK FOR MENTAL HEALTH

By William C. Sandy, M. D., Director Bureau of Mental Health

THE Commonwealth has distinct responsibilities in respect to the mental health of its citizens. Success and happiness, products of mental health, depend largely upon self-understanding and a satisfactory adjustment to life's complex problems. The State should not only provide for the treatment and care of mental patients but should also endeavor to promote the cultivation of desirable personality traits and a favorable environment, both important prophylactic factors in mental health. It was primarily for these reasons that the Legislature established the Bureau of Mental Health in the State Department of Welfare.

The Bureau succeeded the Committee on Lunacy of the State Board of Public Charities when the latter was discontinued and replaced by the Welfare Department in 1921. But its scope and responsibilities are much broader than were those of its predecessor. It administers the Mental Health Act of 1923; it has supervisory duties at institutions for mental patients; it provides expert consultation service; it promotes activities for prevention, such as clinics and educational projects; and it endeavors to coordinate these various activities throughout the Commonwealth.

There are approximately 36,000 patients in the fifty-two State, county and private institutions for mental cases. Bureau representatives, in the course of their visits at these institutions, talk with dissatisfied patients and investigate cases of alleged abuse. They assist in developing plans for the expansion of facilities, and stimulate higher standards of diagnostic study, treatment and care. Special forms of treatment, such as occupational therapy, music and allied activities, are promoted. Social service is stimulated, leading to the parole and rehabilitation of greater numbers of patients.

Penal and correctional institutions also are visited by representatives of the Bureau to permit investigation of the mental condition of inmates—for mental illness, mental defect and personality difficulties are frequently found to be complicating factors in criminal cases.

Since the maintenance and necessary expansion of institutions for mental patients represent a startling percentage of the cost of government, it is highly important that they shall be well equipped and efficiently conducted by qualified leaders in mental medicine, so that the maximum number of patients may be restored to health in the minimum possible time for economy's sake, if for no other reason.

But even more important than institutional care is the development of the possibilities of prevention of mental disorder. Thus the Bureau's community service—clinics, special case studies and other community activities—should gradually become its major project.

No comprehensive mental health program is complete without facilities for research and the education of personnel. The Bureau has long recommended the founding in Pennsylvania of a centre of inspiration for psychiatry, for the intensive study and treatment of selected cases, and for the education of physicians and other personnel in mental medicine. To meet this need the creation of the Western State Psychiatric Hospital has been authorized by the Legislature, to be erected on a site donated by the University of Pittsburgh. Funds have been provided for the preparation of plans, and it is hoped that at the next session it will be possible to appropriate a sufficient amount to permit this important institution to be built.

Another need constantly felt is that of an institution for male defective delinquents (feeble-minded with criminal tendencies), for it is futile to return to the community after a short sentence persons who need long continued supervision. The Cumberland Valley Institution was authorized several years ago for this purpose but has not yet received funds for construction purposes.

The Bureau's aims may be summed up as the stimulation of high standards of treatment and care of mental patients throughout the State and the vigorous promotion of activities for prevention. The carrying out of this program is severely threatened at present by sharp budget limitations. The retrenchment thus caused means the discontinuation or limitation of mental health activities and services vital to the citizens of the Commonwealth. Can Pennsylvania afford this backward step?

THE DAY OF STYLING

every variant from the normal a lunatic, locking him up and forgetting about him is happily long past. Modern mental hygiene work as conducted by the State—with its preventive clinics, its study of problem cases its comprehensive examination and treatment of all forms of mental malady, its attempt to find a niche in life for the defective—is discussed in this issue by staff members of the Bureau of Mental Health of the Department of Welfare.

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EDITORIAL

By Alice F. Liveright, Secretary of Welfare

PERIODS of unemployment slowly but surely produce malnourished children whose frail bodies eventually bear the scars of deprivation. To an even greater extent unemployment produces emotional disturbances and the mental scars of deprivation and frustration. But these changes come about so insidiously that they are noted only when what is regarded as unsocial or markedly regressive behavior asserts itself.

We must be on the alert for these danger signals. Every phase of mental health work—diagnostic, therapeutic and custodial—must be guarded zealously if we are to be prepared to care for the unadjusted, the depressed, the excited and the demoralized individuals for whom adjustment to life is more difficult now than in normal times.

To be sure this costs a great deal at a time when taxpayers are hard hit; but just as in personal budgets the last expense relinquished is insurance, so in the public budget society must be insured against the threat of the unadjusted individual, who in turn must be insured against himself.

Such insurance can be provided only by expert service and care, and accurate measurement of individual needs. This service the Bureau of Mental Health of the Department of Welfare is prepared to render.

THE MENTAL DEFECTIVE AND UNEMPLOYMENT

By Dorothy Durling, Field Representative

ACCORDING to the most reliable estimates at least ninety per cent of the mentally deficient live in the community and constitute a numerically significant section of the population. As might be expected they have been the first to lose their jobs and will be the last to secure reemployment.

This situation has naturally increased the demand, compelling even in normal times, for their care and training in State institutions. But State institutions, crowded to capacity, have no funds for any appreciable expansion at this time. Moreover—and this is something not fully realized—*institutional care is one of the most expensive methods of educating defectives.*

There is only one final answer to the problem: training in the community—a threefold task involving vocational guidance, vocational training, and adequate job placement.

Every mental defective differs from his fellows in abilities. The advice to "stress manual training" is good counsel as far as it goes. But we must also find the respects in which each mental defective differs from others, and make these differences basic factors in choosing a vocation. We cannot neglect any positive asset.

One girl, low in general intelligence, is nevertheless attractive, friendly, industrious, healthy. For her we may consider the service occupations: running an elevator, assisting in a beauty parlor, waiting on table. One boy, physically unattractive, diffident, somewhat suspicious of his associates, has constructive ability of such degree that we may advise an apprenticeship in carpentry for him. He has a real chance to become at least partly self-supporting. Others may qualify as apprentices in farming, plumbing and carpentry, and as helpers on trucks, delivery and errand boys, busboys in restaurants—sometimes even as clerical workers.

Applied psychology is a very new discipline and authorizes no dogmatic choices of occupation. General intelligence tests are useful in limiting the general field of occupations to which the mental defective is suited, but they must be supplemented by other tests and information. Reliable tests have been developed for certain specialized abilities: mechanical, constructive, clerical, etc. There are tests for the eye-hand coordination and manual dexterity necessary for certain kinds of factory work.

We have all been too much inclined to identify "intelligence" with *verbal intelligence*—the ability to manipulate words and symbols effectively, the ability necessary for success in ordinary graded school work. Intelligence is really of many types. It may be *manual* intelligence—the ability to manipulate things, concrete material. It may be *social*—the ability to get along well with others. These other types must receive greater credit and cultivation.

For instance there is Rose, who, although inferior in verbal intelligence, ranks high in the social type. Her associates like and trust her enough to elect her president of the school dormitory in which she lives. She fills the position with fairness and skill. And Robert, weak in verbal intelligence (at twelve he has only first grade proficiency in school subjects) is superior to normal boys his age in constructive ability, making creditable furniture, toys and airplanes.

Vocational guidance is sterile unless it is followed up by suitable training and placement. Only the community can undertake this task. Many public schools have given up their special classes this year for lack of funds, although there is need for more special classes, and more trained investigators to locate working homes and manual apprenticeships, and to supervise mental defectives once they are placed.

Some high-grade feebleminded boys and girls receive vocational training at correctional schools—and this is a real contribution of these institutions. But if vocational training had been provided in the community, commitment to institutions might not have been necessary.

In our preoccupation with feeding the hungry we may be tempted to evade or at least postpone this herculean task. To do so is not the part of far-sighted economy. For unless mental defectives are trained and placed vocationally they will eventually be cared for at greater expense (in both money and human grief) in almshouses, correctional schools, jails, penitentiaries. If we fail to plan for them now we shall foot the bill some day at compound interest.

INSTITUTION WAITING-LISTS

By Florentine Hackbusch, Field Representative

PENNSYLVANIA, like other states, has more mental defectives than can be immediately cared for in State schools and institutions. Hence there is always a long waiting-list of applicants for admission. To many it seems a great hardship that a defective who has suddenly become a family care or a community problem can not be admitted to an institution at once. To the workers of the Bureau of Mental Health who for some years have undertaken the task of investigating applicants in order to determine the urgency of their needs the delay caused by the waiting-list is not without its advantages.

Institutional care is expensive for the taxpayers. Hence the State should be sure that cases accepted for care are both necessary and suitable. During the past year, for instance, 28% of the applications for admission to Laurelton State Village for Mental Defectives were found to be unnecessary.

Not every child who is a problem, nor every girl who is a sex delinquent, is a mental defective. The largest group of unsuitable cases is found among girls who get into Court or some institution for delinquents, are examined when emotionally upset or in poor physical condition, make a low intelligence quotient, and are then considered feeble-minded. Many of these when seen after a period of adjustment present a picture very different from that reflected upon the first examination.

A number of applicants for whom low I. Q.'s are reported prove, upon psychiatric examination, to be mental patients or neurological cases of some sort, rather than mental defectives. Victims of sleeping sickness who present behavior problems or have deteriorated into helpless invalids are often found among applicants for care at institutions for mental defectives. Children who are called feeble-minded on first examination because of unfortunate background, isolated environment, or lack of average educational and social advantages, often show inspiring improvement after periods spent in the foster homes of the Children's Aid Society.

It must be remembered that no mental defective becomes so overnight. One objective of the Bureau of Mental Health is the identification and registration of every mental defective *as early in life as possible*. Workers who are particularly trained in case work with defectives can then advise with the family or agency and assist in making plans. Each defective should be considered individually, but if all who are eventually going to need institutional care were listed as soon as recognized, the institutions would be in a better position to plan their future programs, and emergency cases could be admitted much sooner.

OCCUPATIONAL THERAPY

*By Mary L. Putman**

OCCUPATIONAL therapy in a broad sense is "any activity, mental or physical, definitely prescribed and guided, for the distinct purpose of hastening recovery from disease or injury."

In State hospitals for mental cases, where occupation has long been used as a special form of treatment, strong emphasis has been placed on reaching newly admitted cases as soon as possible, even if the patient may work only a few minutes a day. A definite connection may be found between a patient's occupational interests and his eligibility for early parole.

The occupational therapist's aim is to distract the patient's mind from himself and his environment, to get him to concentrate on a new effort with pleasure and interest, and to observe and record for the ward physician the undiagnosed patient's ability to coordinate, to concentrate and to respond to suggestion.

Modern medical opinion recommends that occupational therapy might also well be used with waiting patients at mental clinics. There is also a growing need for well-developed occupations under trained supervision in out-patient shops to fill the period between discharge from the hospital and reabsorption into normal industrial life.

*Until October 1, Field Representative Bureau of Mental Health.

TRY MORE THAN STRATEGY!

By Augusta E. Galster, Ph D., Field Representative

"Try strategy on Mrs. Straveski," says an advertisement. "You talk the virtues of cleanliness. You argue and reason. Mrs. Straveski is tired. She nods her head—and does nothing. That's when it's good strategy to show her how to get more cleaning done with less work by using Fels Naphtha."

This might have been written almost verbatim for the X family, recently referred to one of the mental clinics. For over twelve years social workers had been telling Mr. and Mrs. X and their eight children (all under thirteen) of "the virtues of cleanliness." They had even "tried strategy." They had moved the family from a dilapidated unsanitary old house to a modern home. They had purchased tooth brushes and had so far impressed them on at least one of the children that, on the social worker's approach, he would hurry upstairs, wet all the brushes, and proudly call attention to their wetness as proof they had been used. The children had been provided with attractive clothes for school, and for a time the worker had visited the home daily in an effort to teach the routine of housekeeping and personal cleanliness.

But after twelve years the workers could point to nothing accomplished. The family could not be interested in cleanliness. Mrs. X, tired with much child-bearing, did not take kindly to the advice and made no attempt to follow it.

The request for clinical examination, made by a social worker who felt that further efforts to help would be sheer waste of time, indicated that this might be a mentally deficient family, with slovenly, irresponsible and antagonistic parents, and children markedly retarded in school.

Yet the clinic examination revealed that both Mr. and Mrs. X had normal intelligence. The lowest intelligence quotient among the children was 94, and one of the children, a girl of five, had an I. Q. of 120. The school retardation was due, not to lack of capacity among the children, but in part, at least, to disgust on the part of the teachers for children who did not look nor smell clean. School attendance was irregular and frequently the children would be sent home to clean up.

At the clinic no one was blamed or scolded, but the parents were told what the children were capable of doing and were led to take equal part in the discussion as to how to enable each child to make the most of his capacities. And after the revelation of the family's innate ability both parents expressed eagerness to help in improving conditions.

"That's what a different approach does," the social worker commented. "We have all been telling them how awful they are, and then you come along and tell them how smart the children are!"

THE SCOPE OF MENTAL HYGIENE CLINICS

By W. K. Skinner, M. D., Assistant Director

PRIOR to the mental hygiene movement mental hospitals functioned as units entirely separate from community life, and were regarded with suspicion and even fear by the average man in the street.

That the mental hospital might contribute actively to community service was not conceived. Families who cent a relative to such an institution felt as though they were parting with him forever, and took the step only as a last resort when all other means of treatment or supervision failed.

The development of mental hospitals as agencies for social service has of necessity been a gradual process beset with many difficulties. The first steps were largely devoted to an investigation of family histories and the following up of causes bearing on the case. A gradual expansion into lines more or less comparable with present day social service was the next logical step.

The value of such contacts outside the hospital was apparent, and soon the institutions, particularly in metropolitan areas, established centers where patients on trial at home might report for examination and where relatives could receive reports on members of the family still under hospital care.

As the public became aware of the nature of these centers it was not unusual for an individual to present his own problems for discussion. The idea of rendering consultation service to patients in no way connected with an institution was thus evolved, and now the modern mental hygiene clinic is found in all parts of the State.

In the type of monthly or bi-monthly clinics established in Pennsylvania the personnel consists of a psychiatrist, a psychologist and a social worker. Where possible this staff is recruited from adjacent institutions, but where this is impractical the Bureau of Mental Health, in conjunction with local social agencies, furnishes the service. The Bureau also provides a central record center and serves in a coordinating capacity, furnishing forms for all examinations and prescribing general methods.

The clinics seek to provide not only for such ambulatory cases as might be presented in the out-patient departments of State Psychiatric Hospitals, but also for early diagnosis and recommendation in a wide variety of cases ranging from infancy to senility. These include:

1. Problem children suffering from physical, temperamental or intellectual disabilities (requiring of course a close liaison with schools and family physicians);

2. Delinquents of the adult type whose offenses may range from sex delinquency to murder;

3. Neurological cases in which there is a pathological condition of the central or peripheral nervous system;

4. Psychotic patients in whom the mental disturbance is of recent origin or who are on parole from a State institution.

Naturally many of these difficulties cannot be met by the simple laying on of hands, but it is remarkable in how many is found an easily solved obvious problem, the treatment of which avoids later institutionalization. In other cases recommendations may be made as to physical care, special school classes or psychotherapy which will go far in alleviating the acute condition.

The clinic does not accomplish its work within four walls. For lasting results it must rely not only upon clinical examinations but also upon the social consciousness of the community as a whole. There is always need for the closest possible correlation of effort between the educator, the social worker, the nurse, the family physician, the psychologist and the psychiatrist.

MUSIC IN WELFARE INSTITUTIONS

By Willem van de Wall, Mus. Doc., Director Committee for the Study of Music in Institutions*

MUSIC in institutions means to many people an orphanage band or prisoners' chorus. But that does not tell the whole story. Welfare institutions are built to take care of those people who for various reasons need special attention and removal from the social group. Their treatment should combine protection of the community with recognition of their special needs. For instance:

Orphans, like all children, crave fun, noise, color, glitter, motion. Here comes the orphanage's glorious band. How firmly the members march in step, how enthusiastically they blow their horns, beat their drums! It is grand indeed to be a bandsman!

In a mental hospital ward sits a woman patient, lost in day-dreams. Whenever talked to, she repeats one answer: "I will never get better. Leave me alone!" In the evening she is escorted to a hospital concert. "Don't ask me to sing," she moans, "I will never get better!" But when "My Bonnie Lies Over the Ocean" is sung by the patients, she first looks curiously around, then suddenly overcoming her inhibitions she chimes in: "Bring Back My Bonnie to Me!"

In the social room of a Home for Crippled Children sits a listless group of boys and girls, with paralyzed legs, lame arm and curved spines. Suddenly the rhythms of a foxtrot record pierce the air. The children are electrified. They stretch themselves, their eyes begin to sparkle, their heads and hands come into lively motion. They accompany the phonograph with singing and all the rhythmic noise which hands and crutches can produce.

Prison! A man sits on his cell cot and stares at the gray stone wall. He mutters: "Fifteen years, seven months and twenty-eight days still to do. Fifteen years, seven months....."

Another man, trumpet in hand, passes by. "Come on, Joe," he says, "come along to the sing!..... A gruff "Go on!" is the only answer.

The man with the trumpet disappears. The man on the cot broods on: "Fifteen years, seven months .....Mike was just as guilty. He drove me to it.....Fifteen years, seven....." All at once the sonorous sounds of an orchestra and singing voices flood his cell. He turns his head, jumps up, grabs his cap, runs down the tier stairs and rushes to the assembly hall. A big fellow hands him a song sheet and yells in his ear: "Here you are Buddy —Number 34." Without Joe's conscious realization his blues leave him and he is singing with the other fellows.

Music in institutions means increased physical vim, happier moods, friendlier and more hopeful thoughts, team work and fellowship. Upon that basis progressive institutions build carefully planned and psychologically controlled handling of adjustment problems.

*Until October 1, Field Representative, Bureau of Mental Health.